

Patient Education in Primary Care

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Welcome to our resource for patient education and primary care!

WHAT IS IT?

This newsletter provides a mechanism to help meet the challenges of incorporating effective patient education into primary care.

WHO IS IT FOR?

VA Primary Care Teams, Patient Health Education Coordinators or Patient Health Education Committee chairs, VISN and VAMC decision makers.

iMed Program for Informed Consent

As all clinicians know, obtaining informed consent from patients for treatments and procedures can be a difficult communication process. A new software program has been customized for VHA to help both clinicians and patients with informed consent discussions. The program, called iMedConsent, guides the clinician and patient through the informed consent conversation. It provides clear, complete, and accurate information about the treatment or procedure the patient is to undergo.

Once installed, the VA version of iMedConsent will be accessed through the "Tools" menu of CPRS. It will enable clinicians to create pre-populated consent forms and capture signatures using an electronic signature pad. The signatures are embedded in the consent form, and the form is saved directly into the patient's electronic medical record. When the completed, signed consent form is saved as an image on the Vista imaging server, a progress note is automatically generated in CPRS. This progress note outlines important aspects of the informed consent discussion—e.g., patient decision-making capacity or refusal of blood products. By saving consent forms directly into patients' records, iMedConsent will assure that documents are available when and where they are

needed and reduce the need for costly, time-consuming scanning that could lead to lost or missing documents and procedure cancellations.

iMedConsent includes an extensive library of patient education documents, drug information, and a wide selection of anatomical pictures and diagrams. These materials enable clinicians to communicate with patients about their specific diseases, prescriptions, and treatments, as well as their general health. The clinician can also easily generate a progress note documenting that educational materials have been provided to the patient. The materials will also allow staff members involved in patient education to distribute consistent and thorough information to patients. This innovative technology will ensure that patients across the VA health care system receive high quality information.

The iMedConsent library has been reviewed and revised by VA clinicians and reflects current VHA clinical practice standards. The software has been modified to conform to VA policy and JCAHO requirements, and it has been systematically tested and favorably evaluated by VA patients, physicians, nurses, administrators, and other hospital staff.



The program will be implemented throughout VHA in a staged roll-out. The software vendor, Dialog Medical, will coordinate the installation of the iMedConsent server at each facility and provide two days of on-site training and guidance. After iMedConsent is implemented at all VA medical facilities, it will be installed at outpatient facilities and nursing homes.

The iMedConsent program was purchased via an enterprise license through the Electronic Support for Patient Decisions (ESPD) initiative of the VHA National Center for Ethics in Health Care. The ESPD initiative employs technology to bring about an innovative, standardized approach to informed consent and related patient decision-making processes.

For more information about iMedConsent, visit: <http://vaww.va.gov/vhaethics/espd.cfm>.

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Patient Education/Primary Care Program Notes

Walking Program at VAMC Milwaukee

It's easy to spot the participants in the walking program at the Clement J. Zablocki VA Hospital in Milwaukee—they all wear T-shirts with the “WAMM” (Walk a Mile or More) program logo as they walk around the grounds of the facility. One of the group members designed the logo and another member printed the shirts.

The walking group formed two years ago as part of the Weight Management Program. Nancy Wilke, occupational therapist and program coordinator, started the group for patients who needed long-term reinforcement to maintain weight loss. “Our initial 8-12 week program helps many patients get started, but they wanted a way to continue getting support from each other beyond those sessions,” said Wilke.

Patients need referrals from their providers to join the Weight Management Program. After a one-hour individual session with Nancy Wilke during which they are given packets of information about cardiovascular health and weight management, patients are invited to attend group classes on healthy eating and to use exercise equipment in the center. During the orientation session and at each subsequent session, patients are reminded that the personal choices are theirs to make. “They are not put on a diet but rather taught that weight management is about personal choices in diet and activity. ‘Whatever works for you—you’re the boss’ is our program motto,” says Wilke. At every opportunity, patients are encouraged to track their own eating and exercise behaviors.

“We suggest that patients set a goal of losing 10% of their body weight at the rate of one pound per week through long-term lifestyle change. At that point they start to see health improvements in terms of diabetes, blood pressure, and lipid management. When a patient reaches the 10% goal he’s eligible for a T-shirt, and he gets his picture taken for the board inside my office, so he’s recognized as an achiever. Patients who lose 15% of their body weight are eligible for a different color T-shirt,” Wilke stated.



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Once patients have completed 8-12 weeks of exercise sessions on the equipment and are comfortable with the idea of increasing their physical activity, they are transitioned away from the stationary bikes and treadmills and invited to attend the walking group. “Not only does the walking group provide an excellent means of burning calories, but it also helps keeps the veteran focused on maintaining healthy lifestyle changes, it provides an opportunity to develop friendship and support, and it requires no special equipment other than a good pair of shoes,” said Wilke.

The walking group meets twice weekly in the auditorium. Usually 10-20 patients attend each session. Prior to the walk, patients get weighed and log their weight on a wallet card. Then patients walk around the grounds, at their own pace, for up to one hour. “Some patients are on oxygen, some use walkers, and some walk three miles in that time—it all depends on what the patient can and wants to do that day,” said Wilke. “We encourage them to find buddies who walk at the same pace; I bring up the rear with some of the slower walkers,” she added. “Miller Park, where the Milwaukee Brewers play, is close to the facility, and many patients enjoy walking around the ballpark,” she said. “Patients walk outside all year long, but if the weather is really inclement, they can workout along with an exercise video in the auditorium or walk the long hallways that we’ve measured for this purpose. We promote additional walking at home or in a mall so they get some exercise every day if they can, and so they don’t view the walking group as their only source of physical activity,” Wilke said.

The group recently finished a 3-month walking challenge. Patients who completed 25 miles received a baseball cap with the program logo, and patients who completed 50 miles received a lapel pin in the shape of a walking shoe to attach to their caps. They could collect multiple pins depending on how many miles they logged. First, second, and third prizes were given to patients in two categories—those who walked the most miles, and those who made the best effort. Throughout the challenge, patients kept logs of the intentional walking they did at home and at the VAMC. A challenge board was hung outside Wilke’s office, and hat and shoe stickers created by Medical Media Service were placed next to the names of patients as they achieved those milestones. At the conclusion of the 3-month challenge, participants gathered for a heart-healthy picnic to celebrate the 55 walkers who logged a total of more than 6200 miles.

For further information contact:

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Patient Education Resources

101 Tips for Behavior Change in Diabetes Education



Anderson RM, Funnell MM, Burkhart N, et al. (2002) 101 Tips for Behavior Change in Diabetes Education. American Diabetes Association, Alexandria, VA.

This book is organized in question-answer format. Each tip is framed as a response to a question from a clinician, for example:

- “What do I do when my patient says, ‘Just tell me what to do’?”
- “Some of my patients seem to accept high blood glucose as normal. I have talked with them over and over about the risk of complications, but they have a fatalistic attitude. How can I help them to understand that there is something they can do about diabetes?”

Although the questions and answers are intended for clinicians who are helping patients manage diabetes, most are applicable to any chronic disease. Chapter headings include: approaches to behavior change; assessment; dealing with emotion; choosing to change; motivation; attitudes, beliefs and values; goal-setting; social support; challenging patients; eating and physical activity; educator-patient relationships; help from other professionals; educator concerns; and pediatrics.

The authors are clinicians working at the NIH-funded University of Michigan Diabetes Research and Training Center.

Teach Tip



Helping Patients Who Are Actively Changing a Health Behavior

Patients at this “action” stage are actively engaged in changing behavior. They may be implementing one or more actions intended to produce change, and they’re working on becoming more consistent with the new behaviors and incorporating these changes into their lives. They believe that change is possible. Their efforts are becoming more visible to others.

This is often an energizing and rewarding stage for both patient and clinician. The patient feels good about the efforts he/she is making, and the clinician feels pleased that the patient is trying to improve his/her health. The clinician’s role at this stage is to support the patient, especially reinforcing positive behaviors and attempts even if outcomes are not evident yet.

Try any of the following strategies, tailoring your approach to the needs of the patient:

- Establish a positive partnering relationship with the patient (*“I think it’s great that you’re making this change, and I’m happy to help you with it.”*)
- Reinforce positive behaviors and attempts regardless of outcome (*“Increasing your physical activity every day is a good thing, even if you’re not seeing big changes yet in your health status.”*)
- Celebrate successes, large and small
- Remind the patient that any change, no matter how small, is better than no change
- Help the patient monitor and evaluate his/her progress
 - Encourage the use of daily logs to track the behavior change
 - Help the patient set realistic goals and plans
- Encourage the patient to talk with others who are working on the same behavior
- Teach additional skills as needed to continue the change
- Teach mental rehearsal skills to help the patient anticipate challenges and handle them without relapsing (*“How will you handle it when _____?”*)
- Be prepared to deal with relapse and help the patient get back on track

How do we know patient education works?

Patient Self-management of Warfarin Treatment

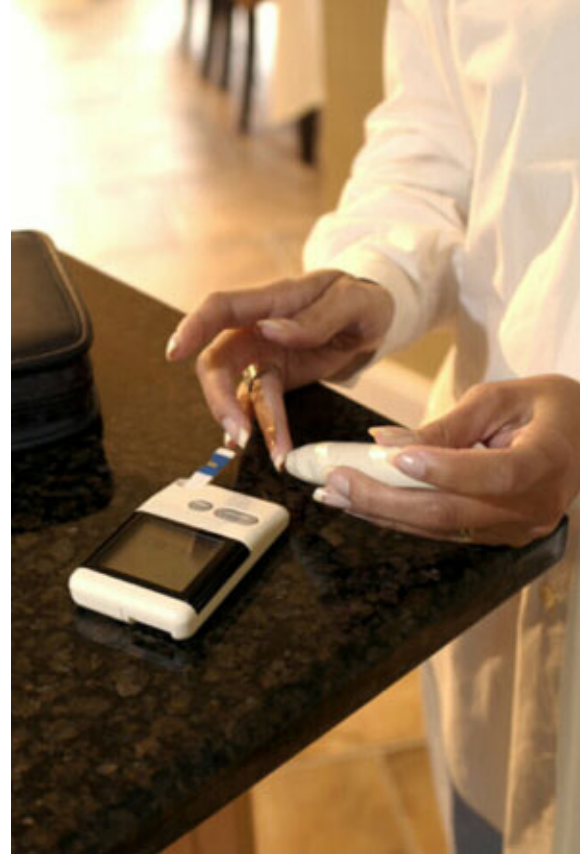
This randomized controlled trial evaluated a point of care coagulometer for testing international normalized ratios (INR). This device is comparable to home glucose monitors. Participants included 608 patients over 18 years of age with a long-term indication for warfarin treatment from 48 general practices in the West Midlands area of England; 327 patients were randomized to the self-management intervention and 281 to usual care.

The self-management program included at least two practice-based training sessions held one week apart. The sessions were conducted by nurses experienced in anticoagulation management and trained by the researchers to present these sessions. Goals of the program were to assure that patients: had a theoretical understanding of oral anticoagulation and INR monitoring, were able to measure the INR reliably using the coagulometer, and were able to interpret the INR in terms of appropriate dose of warfarin.

Patients were individually assessed for self-management skills, including: accurately performing an INR test using the coagulometer, quality control practices, dosing algorithm and adjustment, documentation of INR results, and adverse events. Competent patients were given equipment for home testing. An additional session was arranged for patients who needed more practice; if they were still not considered capable after the extra practice session, they were returned to usual care.

Seventy-four percent of intervention patients (242) completed the training; 212 of these patients completed 12 months of self-management. Patients who completed training were significantly younger and better educated than those who did not. Patients who completed training considered it a convenient and valuable method of controlling their own health. The authors report that most were enthusiastic to continue after the trial.

Murray E, Fitzmaurice D, McCahon D, et al. (2004) Training for patients in a randomized controlled trial of self management of warfarin treatment. British Medical Journal, 328(2):437-8.



Patient Adherence to Skin Self-examination

This study, conducted at Memorial Sloan-Kettering Cancer Center in New York, was designed to determine the impact of a brief, nurse-delivered intervention using digital photographs on patients' adherence to skin self-examination.

Participants included 100 patients at high risk for melanoma skin cancer recruited from the outpatient Pigmented Lesion Clinic at the center. All participants had baseline whole-body digital photography as part of their clinical evaluation. Patients were randomized to receive an educational intervention on the importance of skin self-examination with a photo book of their whole-body photographs and nurse instruction on how to use the photographs; control patients received the same educational intervention but without the personal photo book.

Self-administered questionnaires were used at baseline, post-intervention, and at 4 months to assess adherence with skin self-examination. Among intervention patients, skin self-examination 3 or more times during the previous 4 months significantly increased (from 10.2% at baseline to 61.2% at 4-month follow-up, using paired comparisons).

Among control patients, skin self-examination increased, but not significantly (from 20% to 37%). Comparison between groups showed significantly higher skin self-examination rates among intervention patients.

The authors conclude that the use of tailored, personalized instructional tools such as digital photographs can improve adherence to treatment regimens.

Oliveria SA, Dusza SW, Phelan DL, et al. (2004) Patient adherence to skin self-examination: effect of nurse intervention with photographs. American Journal of Preventive Medicine, 26(2):152-5.



Chronic Illness Self-management

This qualitative study explored how people incorporate chronic illness into their lives. Participants included nine patients with arthritis. The research focus was on understanding the meaning of self-management rather than the experience of managing arthritis symptoms. Data collection methods included autobiographies written by the patients about their life and experiences of living with illness, two telephone interviews with each patient, and a discussion meeting among the researchers and patients.

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Investigators discovered that clinicians and patients have different perceptions about self-management. Clinicians identify self-management as structured education to learn particular skills, but the patients in this study viewed self-management as a process they used to bring a sense of order to their lives. For patients, this process had four themes:

- recognizing and monitoring boundaries
- mobilizing resources
- managing a shift in self-identity
- balancing, pacing, planning and prioritizing.

These patients learned about their responses to illness through daily life experiences, and as a result of trial and error. They reconfigured their lives and reconstructed their self-identity by exploring personal limitations.

The authors contend that clinicians need to approach self-management from a broad, contextual perspective that supports diversity in perspectives. Clinicians also need to create an environment conducive

to learning and engage patients in identifying self-management strategies that have meaning in their lives.

Kralik D, Koch T, Price K, Howard N. (2004) Chronic illness self-management: taking action to create order. Journal of Clinical Nursing, 13(2):259-67.

Diabetes Patient Education Meta-analysis and Meta-regression

This research was conducted by staff in the Department of Medicine at the VA Tennessee Valley Healthcare System in Nashville, TN. The purpose of the study was to identify the components of diabetes education responsible for improvements in glycemic control. The investigators performed a meta-analysis of randomized controlled trials of diabetes patient education published between 1990 and 2000 to determine the effect of patient education on glycated hemoglobin (HbA1c). They also used meta-regression to analyze which variables within an education intervention best explained the variance in glycemic control.

The authors analyzed 28 education interventions used with 2439 patients. Net glycemic change was lower in the intervention group than in the control group. Meta-regression identified three instructional components that collectively explained 44% of the variance in glycemic control, including: face-to-face delivery of instruction, cognitive reframing as a teaching method, and exercise content in the educational program.

Ellis SE, Speroff T, Dittus R, et al. (2004) Diabetes patient education: a meta-analysis and meta-regression. Patient Education and Counseling, 52(1):97-105.



Performance Improvement Training

Every quarter, *Patient Education in Primary Care* will offer the opportunity to earn one hour of performance improvement training credit for a patient education topic of importance to primary care clinicians. To earn this credit, choose one of the following two options:

Read the entire April 2004 newsletter and provide brief answers to the questions below. Turn these in to your supervisor along with a copy of the newsletter

OR

Organize a one-hour brown bag journal club or set aside time during a staff or team meeting to read the newsletter and discuss the questions below. Turn in a master list of participants along with a copy of the newsletter.

Questions:

1. What strategies are or will be used at your facility to promote the iMedConsent program? How might these efforts be expanded? What can you do to help?
2. What kinds of approaches are used at your facility to encourage patients to increase levels of physical activity? What suggestions would you make to enhance these efforts?
3. How is the topic of patient self-management addressed at your facility? What suggestions would you make to enhance these efforts?

DO YOU HAVE ANY SUCCESSFUL PATIENT EDUCATION STRATEGIES THAT YOU WOULD LIKE TO SHARE WITH US?

Contact any of the following
with your input:

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patient education
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committee
chairperson.**

**Coming in
JULY:**

**The MOVE!
Program
(Managing
Overweight/Obesity
for Veterans
Everywhere)**



**Office of Primary and
Ambulatory Care**

**TELL US ABOUT THE TOPICS YOU WOULD
LIKE TO SEE COVERED IN FUTURE ISSUES**